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### ACUTE PUERPERAL CELLULITIS AND TRUE PELVIC ABSCESS.

BY CHARLES P. NOBLE, M. D.

It is my purpose in this communication to report my experience with acute puerperal cellulitis and true pelvic abscess, collecting together in one paper the various cases which I have reported from time to time. The time has now come when such a communication will be received in a proper spirit—that is, as a report of conditions carefully observed at the bedside, and therefore as a contribution to scientific medicine. The first whirl of excitement which followed the discovery of the real nature of chronic pelvic inflammatory troubles has passed by. Men are no longer blinded by the prejudices of the era when all pelvic inflammation was regarded as cellulitis. A sufficient time has now elapsed to enable them to recover from the reactionary wave, during the height of which it was believed that all pelvic inflammation was necessarily tubal in origin. Practitioners of medicine are very prone to be ruled by the dogmas of a few leaders in professional thought, and gynecologists are no exception to this rule. During two generations they gave im-

PLICIT adherence to the dogma of Nonat, Churchill, and Emmet, and during the present generation no less implicit adherence to that of Tait and his disciples. It is now time to accept all the facts in the case whether or not they agree with prevailing theories.

Case I.—This patient I saw operated upon May 8, 1893, by Dr. D. Longaker, who gave me the following history: Mrs. F., aged 26 years, III-para. She was delivered of the third child seven weeks ago, by a natural and easy labor. On the fifth day she had a chill, and chills and fever continued thereafter, also great pain. Dr. Longaker saw her seven weeks after labor, and operated for a clearly-defined mass, situated mostly in the left side of the pelvis, rising up above the brim of the pelvis and extending from the symphysis pubis to the iliac crest. An exploratory celiotomy showed that both uterine appendages were of normal size, but were somewhat fixed by recent adhesions; "neither right nor left ovary nor tube formed any part of the mass; these structures could be distinctly outlined apart from it." Fluctuation was distinct in the swelling as made out by the intra-abdominal finger. A second incision was made above Poupart's ligament, and about half a pint of pus was discharged. The pus cavity was located in the left broad ligament, and extended between the uterus and bladder into the right broad ligament. The patient made a good recovery, but has borne no children since. This is probably because effectual means were taken thereafter to prevent conception.

Case II.—This patient was seen at the Philadelphia Lying-in Charity during my service there as senior assistant physi-

Read before the Philadelphia County Medical Society.

cian. I am unable to find any published notes of the case. My recollection of its salient points is very clear and distinct. This patient was infected after labor, and after a number of days presented the usual evidences of suppuration, together with the signs of intense inflammation in the right side of the pelvis and in the right inguinal region. A hard mass of exudate formed in the right groin, which could be distinctly outlined by palpation. There was every evidence that this was a case of true pelvic abscess, but influenced by the teaching that all pelvic suppuration is intra-peritoneal, an abdominal section was made by Dr. Charles Meigs Wilson, assisted by myself. The uterine appendages were carefully examined, and it was evident that the pus accumulation was entirely distinct from them, and that it was external to the peritoneum. The abdominal incision was closed and the pus let out by an incision made above Poupart's ligament, near the anterior superior spine of the ilium. This patient made an uninterrupted and quick recovery.

Case III.—This case I saw in consultation in the second month of pregnancy. One 1890. The history, as given to me by Dr. Limmewright, is as follows: The patient had a miscarriage, January 3, in the second month of pregnancy. One week later symptoms of pelvic inflammation appeared, and a diagnosis of peritonitis was made. The patient got about by February 1. After a week pain was felt in the right inguinal region, and gradually increased in intensity, extending to the lumbar region. After another week (February 15) she was unable to walk erect and to put her foot firmly on the ground, but had to stoop forward. During this time the temperature remained normal and there were no chills. At times the pulse was slightly accelerated. The pain continued to increase, and on February 27 a swelling was noticed in the right lumbar region. March 1 the temperature rose to 101 degrees F., and the pulse to 120, and there were slight chills. March 2 I saw her. The temperature was normal, the pulse about 90. The right inguinal region was tender, suggesting, indeed, appendicitis, but there were no symptoms to warrant the supposition. A semi-fluctuant swelling was found in the right lumbar region. The next day this swelling had increased, and a hard mass was felt in the right inguinal region, extending as high as the ribs. The swelling in the lumbar region was opened and two or three pints of pus escaped. Introducing my index finger, it passed around the ilium into the iliac fossa. A rubber drainage-tube was introduced, and irrigated daily with a dilute solution of peroxide of hydrogen. This discharge gradually decreased and the tract rapidly healed, closing from the bottom.

It may be asked: "Why is this claimed as a case of true pelvic abscess?" The abscess was undoubtedly situated in the false pelvis on the right side. I had my finger in it. The entire absence of bowel

symptoms excludes perityphlitis. The fact that, on examination, the uterus was found movable and the broad ligaments free from exudate—no fixation of the appendages—excludes pyosalpinx. Hence, I take it, the abscess was due to the breaking down of an infected pelvic gland situated behind the peritoneum, in the right iliac region.

Case IV.—This case was in every way similar to the first. I saw the patient in consultation with Dr. Langrehr, five weeks after labor. The perineum had been torn, and was sutured some hours after labor. Septic infection occurred, and for three weeks the temperature ranged between 100 degrees F. and 103 degrees F. During this time there was no pain or distension of the abdomen, or tenderness of the uterine appendages on examination. The perineal wound became inflamed, however, and the stitches were removed. During the fourth week all the symptoms abated. At the beginning of the fifth week the fever increased and the tenderness in the left inguinal region became marked. Purulent matter had been discharged per vaginam, but whether or not it came from the abscess which had formed was questionable. On examining the patient five weeks after labor I found her very much depressed, in a typhoid condition, with a swelling above the pubes and to the left. Under chloroform a mass of exudate was felt in the left broad ligament extending between the uterus and the bladder, and plainly palpable above the pubes. My diagnosis was true pelvic abscess. I advised median section for an absolute exclusion of complicating pyosalpinx; then a second incision parallel with Poupart's ligament, to evacuate the abscess. This was done by Dr. Langrehr on the following day. The uterus, ovaries and tubes were found healthy. The omentum was, in places, densely adherent. The abscess was situated within the broad ligament, and extended upward behind and two inches above the ramus of the pubes. It contained about six ounces of thick pus, which was evacuated by an incision in the left inguinal region, directly above Poupart's ligament. The ultimate recovery was perfect.<sup>1</sup>

Case V.2—Mrs. G., aged 30 years, II-para, was delivered January 18, 1893, of a living child, after a normal labor. The placenta was delivered by the introduction of the hand. The following day Mrs. G. had a temperature of 104 degrees F., and was suffering from much pain in the right groin and from tympany. On the night of the 20th I saw her in consultation. The temperature was 103 degrees F., the pulse 110, and there was marked tympany and much tenderness in the right groin. A striking feature in the case was that, although

<sup>1</sup> The first four cases have been reported in the Medical News of August 29, 1891.

<sup>2</sup> Annals of Gynecology and Pediatrics, June, 1893.

the bowels were much distended, the abdominal wall itself was not very tense. The coils of distended bowels could be very plainly observed through the abdominal wall. The bowels had not been moved for four or five days. The patient was put upon quinine, strychnine and digitalis, and the bowels were freely moved. Vaginal and intra-uterine douches of corrosive sublimate were employed, although the lochial flow was not foul smelling. The patient's condition remained very much the same until the seventh day, when the right broad ligament became infiltrated, so much so as to be plainly palpable above the brim of the pelvis in the right groin, while from below the anterior and right quarter of the pelvis was filled with exudate closely attached to the pelvic wall and displacing the cervix backward into the hollow of the sacrum. This exudate began to disappear about the fourteenth day, and was absorbed very rapidly. Convalescence was further interrupted by a nephritis, possibly of septic origin, and also by severe intestinal pain accompanied by diarrhea, presumably due to inflammation of the large bowel. The patient was seen in consultation by Drs. Goodell and Parish. She eventually made a good recovery.

Case VI.—Mrs. H., aged twenty-eight years, II-para, was delivered of her second child in March, 1891, the labor being conducted by a midwife. She was infected and was extremely ill. I saw her with Dr. Leopold five weeks after the labor. At that time she was prostrated, with a rapid pulse, "leaky" skin, chills, irregular temperature—in fact, the classical symptoms of septic intoxication.

On examination the right broad ligament was found indurated and a mass of exudate extending on the right side of the abdomen almost as high as the umbilicus. From the extent of the mass it was supposed that a right pyosalpinx with an intra-peritoneal abscess existed; but in view of the puerperal history and the existence of a cervical laceration the possibility of a true pelvic abscess was discussed. A median abdominal incision was made April 16, and the abdominal viscera in the lower right quarter of the pelvis was found fused by adhesions. The patient took ether so badly, becoming cyanosed while still partly conscious, and the pulse was so weak, that I and the gentlemen present were convinced that to attempt the separation of the adhesions, and the evacuation of the pus above, would result in her death on the table from ether. An unsuccessful attempt was made to reach the pus by an incision made near the anterior superior spine of the ilium without giving more ether. The exploration was not pushed, owing to the patient's bad condition. The patient was then put to bed and improved for some days. Operation was again proposed and chloroform selected as the anesthetic, which produced as much cyanosis as ether had done. An incision was now made directly over the broad ligament, the uterus was

located, and the index finger was forced into the broad ligament, evacuating several ounces of pus. With rubber drainage a satisfactory convalescence followed.

October 27, 1892, I operated on Mrs. H. to cure a ventral hernia which had formed at the site of the third incision. On opening the abdomen I was surprised to find that the adhesions throughout the right side of the abdomen, which had been universal eighteen months before, had disappeared, except a point of adhesion between the omentum and hernial sac, and another between the omentum and broad ligament. Both appendages were perfectly healthy. This fact demonstrates what we believed when the pus was evacuated, namely, that it was not a pyosalpinx, but an abscess of the broad ligament.

The disappearance of the very extensive adhesions in this case is worthy of record as showing that peritoneal adhesions are not necessarily permanent.

It is of interest to report that during the summer of 1893 this patient was delivered of a living child after a normal labor, and that she is at present in good health. 3

Case VII.—Mrs. F., aged 18 years, was confined May 8, 1893. She had a mild puerperal sepsis and was in bed for two weeks. The following month she was constantly sick, being in and out of bed, suffering with pelvic pain, anorexia, and having more or less fever. (The temperature and pulse I do not know, as I was not in attendance.) She came under my care six weeks after her confinement, and was admitted to the Kensington Hospital for Women. Examination showed a large inflammatory mass in the pelvis, absolutely anchored to the left pelvic wall. She was under observation for two weeks, with the temperature fluctuating between 99 and 102 degrees F., with the general evidences of mild septic absorption, such as anorexia, sweats, chilly sensations, and increased pulse-rate.

Believing that pus was present in the pelvis, either in the form of a true pelvic abscess or a pyosalpinx, an abdominal section was made on June 26, 1893. The following conditions were found: The uterus was fairly well involuted and was displaced upward and backward by a mass in the left broad ligament. The right broad ligament and the right Fallopian tube and ovary were entirely normal, as was demonstrated not only by touch, but by delivering the ovary and tube through the abdominal incision. The omentum was adherent to the anterior face and upper border of the left broad ligament in front of the Fallopian tube. This adhesion was separated. The left ovary and tube were found to be entirely normal; the meso-salpinx being normal, soft, and movable. This was demonstrated not only by touch, but by vision, the woman being in the Trendelenburg posture, so that the entire left side of the pelvis was in plain view. The left

3 Reported in *Annals of Gynecology and Pediatrics*, January, 1893.

broad ligament was very much infiltrated with inflammatory material and firmly anchored to the anterior and left bony wall of the pelvis. Fluctuation was not apparent. It was determined to close the abdomen, and if septic symptoms persisted to open the broad ligament from below. That portion of the omentum which was adherent to the broad ligament was ligated and cut off. A small gauze drain was placed against the broad ligament where the omentum had been separated, so that, should pus make its appearance at this point, it would find its way out through the abdominal incision.

The patient's convalescence was uninterrupted; the temperature rapidly dropped to the normal, and her general condition steadily improved. The gauze drain was removed, good union of the abdominal incision was obtained, and the patient was discharged from the hospital at the end of four weeks. In the meantime, not only had her general condition very much improved, but the pelvic mass had almost disappeared.

This patient consulted me January 9, 1894, to ascertain the cause of a suppression of menstruation of three months. I found her to be between three and four months pregnant. A careful examination of the left broad ligament failed to discover any evidence of the former cellulitis, the left broad ligament feeling exactly like the right one.

The evidence of the existence of acute puerperal cellulitis as a primary condition in this case is absolute. There was not even a complicating pelvic peritonitis in the ordinary sense of that term, merely a point of adhesion between the omentum and the broad ligament, which was, of course, due to a small circumscribed area of peritonitis. I was able to demonstrate these conditions to a number of physicians who were present, including among others Dr. Fullerton, of the Woman's Hospital.

What I wish especially to insist upon is that in this case neither Fallopian tube was involved in the inflammatory process—that both were entirely normal. The left Fallopian tube and its mesentery were scarcely even congested. The circumscribed area of peritonitis where the omentum was adherent to the broad ligament was plainly due to the fact that the inflammation had extended directly through the broad ligament to the peritoneum, leading to the adhesion of the omentum. That this is possible has been denied by those who maintain that all pelvic inflammation is due to infection which has spread through the Fallopian tubes. In this case the conditions present were unmistakable.

We thus have seven cases in all of

which, except the third and fifth, an abdominal section was made, so that we have the evidence not only of the usual physical examination, but also that obtained from an intra-peritoneal examination. In Cases I, II, IV and VII, the abdomen was opened and the uterine appendages were examined, and it was demonstrated that they were either free from disease, or at the most lightly attached by recent adhesions. In these four cases there is not a shadow of a doubt that the disease was in the broad ligament, and that it spread to the broad ligament directly from the uterus or vagina by way of the lymphatics.

Case VI was undoubtedly not a case of pyosalpinx, and I have no question myself that the pus was located in the broad ligament. A carping critic might affirm that, even although it was not a pus tube, the pus was intra and not extra-peritoneal, and that it was due to suppurative peritonitis. My opinion that the pus was in the broad ligament is based upon the fact that the pelvic exudate was anchored to the anterior and right pelvic walls, and that when I cut down upon the mass I recognized the uterus and tore through the broad ligament with my finger in front of the Fallopian tube.

The evidence in Cases III and V is not so absolute as in the others, and they are included in this list not for the sake of demonstrating the occurrence of puerperal cellulitis, as is done by the other cases, but because of their relative bearing upon the subject.

The foregoing cases demonstrate several interesting facts with reference to obstetrics and gynecology:

1. That in the puerperal state, pelvic cellulitis and true pelvic abscess occur as the result of septic inflammation.
2. That inflammation may spread from the vagina or uterus along the pelvic lymphatics to the broad ligaments without involving the Fallopian tubes.
3. That peritonitis can be set up by the spread of inflammation from the broad ligaments to the peritoneum without involvement of the Fallopian tubes.
4. That very extensive pelvic exudate and intra-peritoneal adhesions can be absorbed.

It hardly seems worth while to bring evidence to bear in support of our first proposition, and it would not be called for were it not that a few men of wide experience maintain the contrary. Being able to present absolute evidence in



the shape of carefully and thoroughly observed cases occurring in my own practice, I shall not take the time or trouble to make reference to the literature.

What I have said concerning proposition one is equally true of proposition two, which is distinctly proven by certain of the foregoing cases. Case VII is a beautiful illustration of the fact that a very extensive puerperal cellulitis can be present and yet the Fallopian tubes be entirely healthy. In this case they were scarcely, if at all, congested, and the meso-salpinx was entirely free from infiltration.

The third proposition is likewise proven, especially by Cases IV and VII. In both of these cases the omentum was adherent to the broad ligament, although the tubes were free from disease. I have no doubt that pelvic peritonitis is usually due to the spread of inflammation from the endometrium through the Fallopian tubes to the peritoneum, but these cases show that this rule is not without exceptions. Numerous other exceptions have come under my observation. For instance, a short time ago I did a hysterectomy for a fibroid tumor, in which the tumor, being impacted in the pelvis, was adherent to the rectum and posterior pelvic wall, over an area of at least nine square inches, and yet in that case the Fallopian tubes were entirely normal. In several cases of appendicitis I have found the peritonitis to extend to the pelvis, the Fallopian tubes having nothing to do with its occurrence. Moreover, it is a well known fact that when small tumors, especially dermoids, become wedged in the pelvis, or become twisted upon their pedicles, that peritonitis ensues. Likewise, that in cases of malignant disease of the abdominal or pelvic organs adhesions are almost always present. Therefore, it must be admitted that pelvic peritonitis can occur independent of salpingitis.

Case VI demonstrates our fourth proposition. In that case the entire right lower quarter of the abdomen was fused together by recent peritoneal exudate, and light adhesions had formed in the left half of the pelvis, yet 18 months later, when the abdomen was reopened, the entire mass of adhesions had been absorbed, with the exception of a small point between the omentum and right broad ligament, and another small point between the omentum and the hernial sac. Owing to the very extensive char-

acter of the adhesions in this case, it is a striking example of the fact that recent adhesions can be entirely absorbed.

Two women of the seven whose cases have been detailed in this report have been delivered of living children since their recovery from the attack of acute puerperal pelvic cellulitis.<sup>4</sup> The subsequent history of four of the other five women is unknown to me. The fact that two of these women have borne children is of interest because of its bearing upon the question of the relation of pelvic exudates to sterility. As this paper has dealt only with demonstrated facts, I shall merely suggest that the occurrence of pregnancy after the existence of extensive exudates, forming during the puerperal state, is best explained in many cases by the fact that the condition present is a puerperal cellulitis rather than a diseased tube. It is a severe tax upon my credulity to accept the statement that extensively diseased tubes, more especially pus tubes, can so far recover as to permit the occurrence of pregnancy; and I believe that the true explanation in not a few cases of pregnancy following the recovery from puerperal pelvic inflammation is, that the disease was originally in the broad ligament and not in the Fallopian tube.

In conclusion I wish to say a few words concerning the relative frequency of acute puerperal cellulitis and inflammation of the Fallopian tubes. I believe, as firmly as anyone, that pelvic cellulitis and true pelvic abscess are comparatively rare conditions, and that the usual variety of pelvic inflammation is a salpingo-peritonitis. I have not met with pelvic cellulitis except in the puerperal state, and have no reason to believe that it occurs in the non-puerperal state, except as a result of infected wounds of the vagina and perineum. As such conditions are very infrequent, a pelvic cellulitis in the non-puerperal state would be a surgical curiosity.

I have added these remarks lest it might be inferred by the unthinking that I am desirous of supporting the old and abandoned theory of Nonat and Emmet concerning pelvic inflammation. At the same time I am glad to be able to present incontestable proofs of the occasional occurrence of acute puerperal pelvic cellulitis and true pelvic abscess.

<sup>4</sup> Since writing this article I have learned that Dr. Himmelwright's patient (Case III) has been delivered of a living child, after a normal labor.

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PHILADELPHIA, SEPTEMBER 29, 1894.

### MR. ERICHSEN AND "RAILWAY-SPINE."

We have before us a remarkable communication, recently published in the Texas Medical Journal.

In a recent issue of this exchange, W. Swearingen contributed an article in support of Mr. Erichsen's position on spinal concussion, incidentally, in the meantime, laying the lash unsparingly over the backs of the railway surgeons, who were among the first to refute the Englishman's views and demonstrate that they had no foundation in fact and had been widely utilized as a surgical gospel of those who were out for plunder.

A member of our staff at the late meeting of the National Association of Railways Surgeons in Omaha, in the most exhaustive essay ever submitted in this country, took a defiant and aggressive attitude on the subject of spinal injuries, and denied, absolutely, that a spinal injury sustained on a railroad

formed any distinguishing or characteristic features whatever. His position he fortified by the clinical histories of more than a hundred cases of every conceivable type of spinal injury; besides an extensive series of experiments on the rachidian structures of the lower animal. (A clinical and Experimental Study of Traumatism of the Spine).

Mr. Erichsen's position was taken seriously, and one after another of his propositions were analyzed and proven fallacious. That the spine may be and often is seriously hurt in railway travel was not disputed, but that railway spine was an independent entity was emphatically combated.

It was also denied that there was such a condition as "concussion of the spine;" that it was a physical impossibility without a coincident association of the mortal injury of the more exposed internal organs.

Now Professor Erichsen comes forward himself, and practically confesses that his mischievous teachings in this line were all wrong. He says:

"Nearly thirty years have passed since I first brought the subject of railway and other injuries of the nervous system under the notice of the profession. At that time (1866), the pathology of the nervous system and of its injuries was very imperfectly understood, and even its modern nomenclature had not been invented. 'Neurosis' and 'neurasthenia' even, were unknown terms, and what I then, for want of a better name, called 'concussion of the spine,' is now universally recognized and described under the more modern appellation of 'traumatic neurasthenia.' The morbid states are the same, and the symptoms identical; but the name has been changed, and the modern designation is probably more in accordance with modern views than was the older one. In all my writings on this subject, I have pointed out that the symptoms arising from railway shocks are identical with those that occur from other and more ordinary accidents of civil life, and that these symptoms so occurring had been described by surgeons many years before railways were dreamt of, and fully a century before I had written a line on the subject."

This is rather a late date to make a retraction; but let us hope it will soon become as widely diffused as the doctrines it repudiates.

Here we have an acknowledgment by the author himself, that in "concussion of the spine" the cord may be in no manner whatever implicated; indeed, that we may have the play of "Hamlet" with Hamlet left out; for everyone knows that in the new fad of the specialist, the so-called "traumatic neurosthenia," the dominant symptoms are psychical, a sort of mixture of hysteria and melancholy—a state which any designing woman may work up to perfection before a jury any time in 15 minutes.

Thanks to the patient, persevering effort of the late immortal Watson and the indomitable energy of American investigators, who have attacked and annihilated the arguments and hollow, shaky foundation of railroad concussion, the time had come when they wrung from the author and originator of the phantom a confession that he was wrong and they were right.

#### "HE WAS ATTENDED BY FOUR DOCTORS."

How often we see this expression, or one similar to it in the lay papers, after an account of some slight or severe accident. There recently occurred such an account in one of the daily papers, where a man had been injured and copious hemorrhage had taken place from an incised wound, the item concluding by the announcement that "he was attended by four doctors before the hemorrhage could be stopped."

This, on the face of it, looks bad for the profession at large. We do not know the facts in this particular case, but it too often happens that such items get into the daily papers. Every physician ought to know enough to stop an external hemorrhage, especially of a limb, which was the case in the above quoted report. If he can do no better he can put on compression or a tourniquet. A hue and cry is raised over the hospitals and free dispensaries cutting into the practice, and yet there is hardly a physician who, when an accident befalls a person, and to whom he is afterwards called, but will shift the responsibility of the case over onto the hospital rather than send the patient to his own home and undertake the case himself.

Every physician should be thoroughly versed in emergency treatment. It is sometimes a delicate matter to decide off-handed what is best to do under cer-

tain circumstances and in certain accidents. Sometimes the hospital is the best place; this is especially true if the patient be poor or dependent on his wage, and the accident be one which is likely to prove expensive to him to treat, perhaps requiring expensive apparatus. But that one or two, at the most two, physicians should not be able to control a hemorrhage of the limb, until the patient had nearly bled to death seems almost absurd.

There is, of course, another side to the question, and that is the extravagancies of the lay press in reporting such cases. Reporters often see more doctors than there really are, or at least like to report an accident case as being worse than it really is, but for this the profession is not to blame. What we wish to see is more prompt and decisive action taken for the welfare of the profession.

#### PROPERTIES OF A TRUE ANTI-PYRETIC.

The properties of a true antipyretic are summed up by Sir Benjamin Ward Richardson in the following brief but practical way:

"We have empirically discovered some medicines which have the effect of reducing temperature; but what is really wanted is principle in this matter, as opposed to mere empirical observation. The substance to be used medicinally, for this purpose, must have three qualities:

"1. It must be antiseptic.

"2. It must be volatile.

"3. It must have the slightest solubility in blood.

"If it be not antiseptic it is negative in its action as a suppresser of animal heat. If it be not volatile it accumulates in the blood and tissues, acts then as a foreign body toxic in its nature, and causes itself secondary symptoms which are mischievous and unnecessary, taxing active eliminating organs, like the kidney, to an undue degree. If it be very soluble in the blood and in the fluids of the tissues, it is the more objectionable on account of its fixation and slow elimination.

"The value of ammonia as a medicine rest largely on its possession of the three qualities named above. Ammonia is a splendid antiseptic, and it is volatile, but it is too soluble, and too

powerful a solvent. Given in sufficient dose to check the animal fire, it dissolves the red corpuscles, prevents the free absorption of oxygen from that effect, and by its presence in the blood also tends to prevent oxidation.

"Chloroform possesses many of the properties required. It is a splendid antiseptic; it is volatile; and, feebly soluble in blood, it does not produce any fixed toxic symptoms, nor tax the eliminatory organs unless carried to anesthesia. I have used it as an antipyretic for over forty years, and with much satisfaction; but the difficulties of its correct administration have stood much in the way.

"Hydrate of chloral, an agent of this same class, is more manageable. It is an antiseptic; it turns into chloroform and sodium formate in the body, so that it is both volatile and eliminative, and unless it be pushed too far it is not toxic. In my first observations made on it immediately after Liebreich's discovery of its narcotic effects, I discovered its remarkable power of reducing animal temperature, and pointed out that when it kills by a large dose, the mode of death is by reduction of temperature of the body. Since then I have employed it regularly as an antipyretic, and the results I have witnessed from its use surpass all others. It is without a doubt, when correctly administered, an admirable remedy for pyrexia, and in enteric fever it is, I believe, the best."

### Correspondence.

To the Editor of the "Times and Register:"—In your issue of Sept. 15, on page 167, I read with interest the article, "A Boycott against Pharmaceutical Manufacturers," and feel constrained to say a word in behalf of physicians. The so-called "regular" manufacturers of pharmaceutical preparations have seemingly, with the aid of the druggist, labored diligently for years to ruin the practice of the physicians. They put their goods on the market prepared and directed in such a way, that, after the "chump" of a doctor is so foolish as to once indorse them, by prescribing them, the druggist becomes the doctor and takes charge of the case, and sells the "stuff" directly to the patient. The quack advertisements of these nostrums

are piled up in every drug store, and handed to every customer, and the wonderful virtues of the "Great Cure Quick" that the doctors recommend, distributed far and wide by the aid of the doctors. There are many druggists who, when a patient presents a prescription from a physician, will receive it with a skeptical grin, criticise it, or advise the patient to try a bottle of some of the so-called regular "stuff" from the opulent manufacturers, or fill the prescription, and refill it for any and all who apply for it. This cut-throat business has gone on for years until finally the doctors are beginning to wake up and keep their own drugs; hence this pharmaceutical kick.

My own experience and observation is that the doctor who keeps a supply of medicines in his office has a decided advantage over his brother physician who does not, and saves his patient from extortion and furnishes him a better grade of drugs.

J. A. HOUSER, M. D., Indianapolis, Ind.

We are glad to see the physicians waking up to this subject, and trust we may hear from others of our subscribers.—Ed. T. and R.

### A POCKET PHARMACY.

Editor "Times and Register:"—To be provided with a pocket pharmacy that shall be sufficiently comprehensive to meet the variety of cases that apply in church, places of amusement, and on the street, while at the same time it is sufficiently compact to carry without inconvenience, has long been the dream of the profession, never realized until the introduction of the alkaloidal granules of the active principle.

The writer of this, some years ago, adopted a case, which has been extensively introduced by the various granule manufacturers until it is carried, probably, by more physicians than any other one style of case on the market. Most cases are so large that they are cumbersome, and are soon thrown aside, the physician trusting to luck not to need it, or to get along with his hypodermic, or a stray vial or so that he may chance to have in his pocket.

This little case is adapted in size and style to be carried in the upper vest pocket, where it finds abundance of room (and in the writer's own pocket it leaves space to accommodate a fever thermometer, a fountain pen and a pen-



cil). As will be seen by the cut, it carries nine vials; these are of half-dram size, and will hold 100 each of the average sized granules.—900 doses. So you see it is multum in parvo.

With what this shall be filled depends upon the physician himself, his style of practice, and the cases he will meet. In my own case, at this season of the year (I always change a trifle to fit the season), will be found, 1st, glonoin (nitro-glycerine, or trinitrin, as it is sometimes called), gr. 1-250, and of all the remedies for an emergency case this stands pre-eminently the most important. To relieve spasm from any cause, to stimulate a flagging heart, to relieve syncope or pain from internal congestion, this drug stands without a peer. A granule chewed and allowed to absorb from the tongue, or dissolved in a teaspoonful of hot water, and poured between the set teeth of a spasmodic patient, relieves like magic, and is often curative in itself. Its action is to dilate the skin capillaries, causing a rush of blood to the surface, relieving congested nerve centres.

2d, and not less important, is the "king of pain," morphine, which I carry in granules of 1-12 gr. each. Nothing need be said on the uses of this drug, except that where a quick effect is needed, the same is hastened by solution in hot water, and the use of the hypodermic thereby avoided.

I will mention hyoscyamine third, and strychnine arseniate fourth. Pages might be written on the use of these two, but I will simply suggest the action of the first to relieve pain and spasm by dilatation of constricted circular muscle fibres, as in colic dysmenorrhea, asthma, etc., and the sustaining action of the last, which would indicate its use to guard against relapse, with all remedies applied to the relief of acute conditions attended by a faltering of any organ. Nausea is often quickly overcome with a granule of zinc sulpho-carbolate, gr. 1-6, and so I number this fifth; with codeine, gr. 1-67, sixth, it will not only relieve a worrying child, suffering with pain and languor from a decomposing dinner taken into a stomach not ready to receive it, but many other conditions that will present themselves. Aconitine amor., gr. 1-134, in this naming comes seventh, giving its usual first place to glonoin, but is none the less useful for all that. It should be added to the treatment of all conditions attended with fever. The size here given is adult

dosage, but with judgment may be used undissolved at all ages from 10 years up; in other cases it should be dissolved in water in appropriate quantity. This leaves two more loops, which are occupied by calomel, gr. 1-6, and digitalin, gr. 1-67. With this assortment we cannot only meet emergencies, but can do a large per cent. of an extensive practice; and the case is so small and compact that its presence is often forgotten until the need arrives when it proves itself "a little giant," as some have called it.

To be always prepared is the duty of the physician. It pays in more ways than one and how this can be accomplished to the best advantage should be a matter of more than passing interest.

I shall be glad to answer any questions that may arise in this connection by personal letter or through the "Times and Register."

W. C. ABBOTT, M. D.

Ravenswood, Chicago, Ill.

#### DIPHTHERIA ANTITOXINE.

Translation.

Berlin, S. O., Aug. 22, 1894.—Dr. Hans Aronson, Berlin. My Dear Doctor:—I have seldom experienced the satisfaction in the treatment of a sick child as was my fortune in the following case, which I feel bound to report to you in brief. It was in a child of seven, suffering from a severe, though not purulent diphtheria. I employed your antitoxine, and after two injections of two cubic centimetres of the lymph, the pharyngeal diphtheria, the hoarseness and the acrid discharge from the nostrils retrogressed with a promptitude that excited my wonder and admiration, and in which a colleague whom I had called in consultation fully concurred. Before applying the remedy I had seen the diphtheritic exudation spread unto the uvula, and involve the entire pharyngeal lymph-ring; the child was somnolent, and its pulse beating 60-65 to the minute, was weak; I was naturally very anxious lest I should lose the case. For three days the child's condition, under all manner of treatment, got steadily worse; but when the injections were begun, the exudation rapidly diminished in the pharynx until there were only a few shreds left on the tonsils. To-day the little girl is playing; the membrane is entirely gone; the mucosae are only slightly reddened; and the swollen glands of the neck have almost entirely retrogressed.

The results in this case have been such that I cannot forbear to express to you my sincerest thanks for the preparation you have placed at our disposal. Fraternally yours,

(Signed)

C. S. ENGEL.  
4 Wenden strasse.

## Surgey.

Under the charge of T. H. MANLEY, M. D., 115 W. 49th St., New York.

### HERNIA IN THE LINEA ALBA.

Lenhoff of Litten's Poliklinik, describes (Berl. Klin. Woch., July 30, 1894), a thrill to be obtained in these epigastric herniae similar to the hydatid thrill. He first calls attention to the symptoms, and the importance of not confounding this hernia with other diseases. It may simulate catarrh of the stomach and gastric dilatation. There is frequently pain after food, nausea, vomiting, wasting, constipation, or perhaps alternating diarrhea. The hernia is mostly present midway between the umbilicus and the ensiform cartilage. It may be so small as to be felt only in certain positions of the body. Palpation is painful. For a short time it may be replaced when the defect in the linea alba can be felt. Patients are generally over 30. Whether the contents are gut or omentum makes little difference, as the treatment is the same. If the fingers are placed on the hernia, and the patient makes a few successive coughs, a sensation is obtained as if the fluid were being driven up against the fingers. The author records two cases in which this thrill was obtained. It has been present in all cases examined by him. It occurs also in hernia in other situations.

### A NEW SYMPTOM OF CANCER.

G. Bogdan (Bull. de la Soc. des Med. et des Naturalistes de Jassy, 1894, I) relates the case of a woman, aged 48, who suffered from cancer of the stomach. The disease had gone through a prolonged period of latency. The patient presented on each cheek a patch of wine-red discoloration formed by the dilatation of the superficial venules; the stain showed out sharply against the pale yellow of the surrounding skin. On the strength of this symptom alone Bogdan was able to make a diagnosis of probable cancer at a time when there was yet no other manifest sign of that affection. He looks upon such superficial varicosities on the cheeks as a valuable help to the early recognition of certain cancers; he has seen it in about two-

thirds of the cases of cancer which have come under his observation. He says it is particularly frequent in cases of epithelioma of the stomach and uterus, but less common in malignant disease of other organs.

### NEW BELLOWS FOR ARTIFICIAL RESPIRATION.

Dr. B. Ward Richardson has invented a new bellows for artificial respiration, which he describes as follows:

"The instrument consists of a small pair of bellows provided with two nozzles, each containing a valve acting in opposite directions to each other, and so arranged that when the bellows are opened they draw in air—this is to say, exhaust from one nozzle—and when the bellows are closed they throw out a current of air from the other nozzle. Each tube terminates in a nostril tube of suitable shape to fit nostrils of various sizes.

"In employing these bellows for artificial respiration the patient is placed in the recumbent position, or with the head downwards. An assistant then inserts the nozzle of the exhausting tube, which is marked "exhaust," into one nostril, hold it there in position, and closes the free nostril between his thumb and finger, the mouth also being closed. The operator now makes a few strokes of his bellows, by which the lungs are emptied of their contained air. The nozzle of the exhausting tube is then removed, the bellows are emptied of the expired air which they contain, and are filled with fresh air. The nozzle of the injecting tube is next inserted into one nostril, and held in position with the free nostril and mouth closed as before. Lastly, the operator gently injects the chest with fresh air until the lungs are filled with as much air as was drawn out of them by the exhaust movement. This process of alternately exhausting and injecting air can be repeated three or four times a minute, until natural respiration returns. There is no occasion whatever in using the bellows to attempt to follow artificial respiration as quickly as natural respiration; the grand point is to exhaust the lungs of lethal air and to refill them with pure air without disturbance or rough treatment of the body. The bellows might be attached with advantage to the operating table, and as they are easily carried they might enter into the bag of the anesthetist or obstetrician.

## Therapeutics.

Under the charge of LOUIS LEWIS, M. R. C. S., Philadelphia.

### SALOPHEN IN DISEASES OF CHILDREN.

Dr. Richard Drews (Allg. Medicin. Central Zeitung, No. 60, 1894) has treated with salophen 15 cases of acute articular rheumatism in children varying from 7 to 14 years. In five cases one or both knee joints were affected, in four both ankles, in four both shoulder joints, and in two all the joints of one side of the body. The remedy was administered in accordance with the age in doses of 0.3 to 0.5 gm. every two hours and 3.0 to 5.0 gm. pro die, and in no instance was any influence upon the heart noted. In the majority of cases the pains were already relieved on the first day and vanished completely at the end of three or four days; the temperature always fell to normal in the course of three to four days coincidently with the subsidence of the swelling. In 12 out of the 15 cases profuse perspiration occurred about half an hour after the exhibition of salophen, which, however, had no effect upon the general condition. Aside from this no after effects of any kind were observed. An extension of the affection from one joint to another did not occur; in two cases, however, three to four days after subsidence of the swelling a recurrence ensued, which again disappeared after three days' use of the remedy. Salophen therefore has the same effect in acute articular rheumatism as salicylate of soda while free from its unpleasant sequelae, such as gastric disturbances, tinnitus, vertigo, cardiac depression. An equally satisfactory result was obtained in five cases of severe acute muscular rheumatism of the muscles of the neck in which a cure was effected at the end of three days. In a case of purpura rheumatica in a girl 14 years old, salophen in 0.5 gm. doses every two hours also had a favorable action upon the pains, fever and eruption. A case of chorea is reported in which under administration of 5.0 gm. pro die for 12 days the choreic movements as well as a coincident systolic murmur disappeared completely. As an

antipyretic salophen proved serviceable in various febrile diseases, typhoid fever, scarlatina, pneumonia, tuberculosis, acute tonsillitis, the temperature being reduced 1.5 to 2 degrees C., in the course of half an hour. As an antineuralgic it acted admirably in a number of cases of migraine in children varying in age from 8 to 13 years, the pains being completely relieved by two or three doses of 0.3 to 0.5 gm. On the ground of his experience Drews therefore concludes that salophen is an excellent remedy in acute articular rheumatism, deserving preference over all other drugs in pediatric practice; that it is a useful antipyretic and an excellent antirheumatic. It was always well borne, and being tasteless can be administered without difficulty.

### CREOSOTE CARBONATE IN TUBERCULOSIS.

It is quite erroneous to assume that the creosote carbonate treatment is a more expensive one than that by a ordinary Beechwood creosote. On consideration, it will be found that it is really the more economical method of the two, and particularly is cheaper than creosote pills or capsules. It must be borne in mind that the creosote carbonate is administered in liquid form, whereas the Beechwood creosote, by reason of its irritating effects, can rarely be taken in a pure state; and when dispensed in the form of pills or capsules its cost is increased so much that it is really greater than that of creosote carbonate. It may, indeed, seem that creosote carbonate is more costly; but this is because so much larger doses of the carbonate are used, and are well tolerated by the patient; nor must it be forgotten that the larger doses are very much more efficient. The expenditure at the moment may be greater, but it is confined to a shorter time. As a matter of fact, it requires less money to effect a cure with the creosote carbonate, than with the ordinary creosote treatment. The creosote carbonate treatment takes but a fraction of the time that the older methods do, and when we consider the expenses incident on prolonged sickness, the balance is greatly in favor of the new method.

## Medicine.

Under the charge of E. W. BING, M. D., Chester, Pa.

### THE TREATMENT OF VOMITING IN CHILDREN.

The Journal de Clinique et de Therapeutique Infantiles for August 23 publishes the following directions and formulas to be used in the treatment of vomiting in children: Very young children should be made to swallow small pieces of ice before nursing. Milk diluted with a little Vals or d'Alet water should also be given. Before the child is nursed, three grains and three-quarters of bismuth subnitrate should be put on its tongue. The diet should be restricted, the milk sterilized, and the time of nursing properly regulated. For older children, iced drinks, ice, and effervescent waters are recommended. A teaspoonful, each, of the following mixtures is to be taken, beginning with the first: 1. Potassium bicarbonate, thirty grains; syrup, two hundred and twenty-five grains; water, an ounce and a half. 2. Citric acid, thirty grains; syrup of citric acid, two hundred and twenty-five grains; water, an ounce and a half.

Fonssagrives recommends the following: Essence of cajuput, from six to twelve drops; sugar, thirty grains. When this is thoroughly mixed, add an ounce of syrup of tolu and three ounces of Melissa water. From a teaspoonful to a tablespoonful is to be taken every hour. Huchard prescribes seventy-five grains of tincture of iodine and two hundred and twenty-five grains of saturated chloroform water, of which from two to six drops are to be taken in a little sweetened water.

For nervous children, over twelve years old, Ewald prescribes cherry laurel water, three quarters of an ounce; tincture of belladonna, seventy-five grains; cocaine hydrochloride, four grains and a half; morphine hydrochloride, three grains. From five to ten drops are to be taken every hour or two. The following formula is recommended by Gaibourt: Syrup of lemon, three hundred grains; lemon juice and orange-flower water, each two hundred and twenty-five grains; linden water, two ounces; Sydenham's laudanum, nine grains; sulphuric ether, fifteen grains; potassium bicarbonate, thirty grains. The bottle should be corked immediately,

and from a quarter to a third of the mixture is to be taken at once. Le Bariller advises the use of the ether spray over the epigastrium; also blisters or the actual cautery over the same part.

—N. Y. Med. Journal.

### VOMITING OF PREGNANCY.

A writer in the Lancet says: "I have not failed once for many years, by a single vesication over the fourth and fifth dorsal vertebrae, to put an end at once to the sickness of pregnancy for the whole remaining period of gestation, no matter at what stage I was consulted. The neuralgic toothache, and pruritis pudendi of the puerperal condition yielded as readily, and to one application."

### A SINGULAR APOPLECTIC SEIZURE.

We adopt this title for the following case from the Sheffield Daily Telegraph. It is a very appropriate one. Coroners have before now been known to "make remarks," but it is not often that a legal luminary has given such a detailed pathological study as in this instance. The inquest was held on the body of a boy, who, after hiding in a closet, slipped when he came out, and fell over a beam in the roof. There he hung for five minutes, and when he was got down "he looked white and ill, and complained of feeling sick." The Coroner remarked "that it was a singular accident, but he was satisfied that the lad had broken a small blood vessel on the brain. The heart would pump the blood through the fracture, the lad would turn sick, go insensible, and then die. That of course was nothing else than apoplexy." The jury, in accordance with this oracular utterance, returned a verdict that the deceased died suddenly, probably from an accidentally ruptured blood vessel on the brain. A medical man is mentioned as having been sent for to see the boy, who, however, had died before his arrival. Of course, medical testimony at the inquest was unnecessary with a Coroner so satisfied as to the way the death had been brought about.

—British Medical Jour



## Electro-Therapeutics.

Under the Charge of S. H. MONELL, M. D., 44 West 46th St., New York.

### THE NATIONAL SOCIETY OF ELECTRO-THERAPEUTISTS.

The second annual meeting of this society was held in New York City, September 20 and 21. The morning session was opened by an address upon the subject of Electro-Therapeutic Teaching, by the president of the society, Dr. W. H. King.

In his investigation for the purpose of this paper, he had become impressed with the idea that doctors generally are not electricians. The mechanical side of the subject had so developed that only an electrical workman or machinist could handle it practically, and hereafter physicians should chiefly confine their investigations to electro-physiology and electro-physics. In order to ascertain the extent to which electricity is now being taught in medical colleges, he had sent out letters of inquiry to all the recognized institutions in the United States—140 in all. 93 answers were received, but of these, three were discarded for reasons given.

It was ascertained that 27 colleges had a chair of electro-therapeutics, with lectures and clinics. The number of lectures per course ranged from 8 to 75, an average of 20. Other colleges made some attempt to teach the subject, 8 gave clinics, though not lectures. In many cases where partial teaching was done, the lectures were given by another chair. Only 11 colleges were discovered in which all teaching of electro-therapeutics was omitted. This shows a very rapid growth. Improvement in the quality and character of the instruction given is much to be desired.

Many hold the opinion that the subject is properly one for post graduate courses, but as the number of physicians who take post graduate instruction is relatively small, Dr. King considered that electro-therapeutics was essentially a senior course study. If a student's intelligent interest in the subject was educated up to a just comprehension of its merits before he left college, he would be more apt to carry its usefulness into his practice and pursue post graduate investigation in a spirit worthy to ensure success in its therapeutics.

The less a man knows about a subject before he graduates, the less he is inclined to care for it afterwards, and as the converse of this is also true it is of great importance to the future development of the medical uses of electricity that its value be fully taught in every medical college.

"The Electric Treatment of Appendicitis," by Dr. W. N. Williams, of San Jose, Cal., was then read. The case cited was that of his wife, who was taken suddenly ill in March of the present year. History of attack and symptoms were given in detail, together with a full resume of treatment.

Two applications of galvanism were given daily, with positive pole on the affected region and over seat of pain, the negative being applied to the lower and upper spine in alternation. Current strength was strong as was comfortable.

Medical treatment was continuous during the case, and it would be difficult to describe just what value could be attached to the action of any one agent where so many as here cited were employed.

"How to Measure the Faradic Current," was the title of a brief paper next presented by a maker of electrical apparatus. The first half was occupied by a quotation from the "International System of Electro-Therapeutics." No further light was shed on the subject by the reader of the paper.

The discussion which followed showed how very slight has been the spread of such information as is now definitely known in regard to medical currents.

At least the A B C of medical electricity ought to be generally grasped by the profession at this time, for the facts are abundantly available.

The president, Dr. King, followed with an admirable paper upon "Some Observations on the Influence of Electricity on Muscular Development." He had particularly been impressed with the effects in a case of hemiplegia, treated several years ago, in which the paralytic left side was strengthened so that it finally became more muscular than the right. Since that time he has tested many cases with both galvanism

and faradism, applying them to many forms of weakened muscles; but for the purposes of this paper, chiefly to the muscles of the arms, which could be tested by the dynamometer for increase of strength. Three methods of treatment were tested in both health and disease. Ten minute table applications of mild currents (5 mil.) of both galvanism and faradism produced some slight improvement.

Galvanic currents of 10 millimetres and faradic currents strong enough to contract the muscles were much more effective, but the faradic was by far the most powerful. No special difference between the poles could be discovered when the force of the application was the same for each.

A third method consisted of stimulating motor points with single galvanic and faradic contacts. Each motor point was stimulated six times at each seance. This was the most effective method.

The cause of the more rapid gain seemed to be chiefly the active exercise of the muscles, caused by the vigorous contractions, and when these were equal for each pole, the poles caused equal gains. Small and excessive currents were less beneficial than such as simply caused good firm contraction. The results given were obtained upon healthy muscles.

Thirty cases of diseased conditions were then cited.

It was found that in disease the galvanic current was much better than the faradic, although in health the faradic was the most active. It was also proved that the kind of treatment influences the result greatly—some cases doing well under Method 3 which were not improved by Method 1.

When the reaction of degeneration is present the faradic current is practically valueless, and only acts well in proportion as healthy tissue predominates.

While the results of all cases varied they entirely agreed in corroborating the views generally held as to the relative action of the two currents. The interrupted galvanic current is of the greatest use in keeping up the strength when descending degeneration is present. Galvanism has the power to increase nutrition and strength independent of contractions, while the faradic current has not.

This ability, due to its cataphoric and

catalytic action, when added to the exercise caused by interruption, produces the most admirable effect. The faradic current can only increase nutrition by producing contractions.

Finally the speaker concluded that both poles acted equally when they produced equally vigorous contractions.

"An Investigation of Inter-Polar Action in Galvanic Currents," by Dr. W. L. Jackson, was next read. Various experiments with fresh beef—bare copper electrodes and different intensities of current were described.

A specimen was shown, illustrating the effect of 260 millimetres from 60 cells, the current so applied as to limit the action upon the meat to the inter-polar influence solely.

No more decisive demonstration of inter-polar action could be desired than was apparent in the specimen exhibited by Dr. Jackson.

Dr. Flora A. Brewster next read "Hints on the Use of Electricity in Gynecology."

The length of this paper and the rambling nature of many statements it contained necessitate its dismissal in a few words. Those who found much to question in the paper were of the opinion that a closer adherence to established facts would have produced a better impression. Among the various vagaries noted was an electric belt of "her own invention," so powerful that it gave a current of 3 millimetres on short circuit without resistance, and, strange to say, would give the same current when worn by a patient, regardless of the resistance of the skin.

At one time in the experience of this resourceful electrician, she encountered a patient with obstruction of the bowels. She waited at the bedside to see her die, but meanwhile seized a piece of zinc and placed it in the patient's mouth, put a silver spoon in the rectum, connected the two by a wire, and, lo, the patient was relieved.

Papers read later in the session will be noticed hereafter.

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Vigouroux claims that static electricity is the best vitalizer in the treatment of neurasthenia.

## Miscellany.

### THE USE OF HEMOFERRUM IN THE TREATMENT OF ANEMIA.

—By William Thornton Parker, M. D., Groveland, Mass.

Hemoferrum (blood iron) pilloids are something decidedly new in practical therapeutics. As a tonic this preparation will be found very convenient. Hemoferrum is the element iron united with proteid matter as it exists in the blood itself. It is a natural proteid compound of iron, and contains all the iron present in the blood, it being the principal constituent of the red blood corpuscles.

It is presented in pseudo-crystalline, or semi-powdered, form; of pleasant taste, agreeable odor; neutral in reaction and very soluble. It is not an exosmotic, consequently does not constipate. It is non-poisonous; therefore, if taken in large amounts will produce no disastrous effects. Its continuous use does not injure the teeth, since it is neutral in reaction, and, therefore, non-styptic. Being so readily and easily assimilated, it does not tax the digestive organs when they are in a weakened condition. It is aseptically prepared by an original process, and is, therefore, permanent.

The object of its administration is to increase the blood-making properties, stimulate the appetite, and tone up the general system. All of these desirable conditions we have obtained from its use in our own practice.

In the treatment of consumption we require, first of all, a genuine blood tonic to build up the system, and to strengthen it so thoroughly that the diseased germs are overwhelmed, and the vitality of the patient is so much improved that exercise and fresh air can be obtained without further interruption.

The use of hemoferrum, in combination with a creosote treatment, is the best we can do for our tuberculosis patients to-day.

Recognizing the value of iron as a tonic, our good matrons of the olden time prepared iron water by placing nails in a jar of water. This rusty, musty compound they gave to confiding children to drink, much to their disgust and precious little to their benefit.

Now all this is changed. The medical man prescribes elegant preparations of whose honest manufacture and scientific value he is reasonably certain. No tonic pills ever devised have excelled these hemoferrum pilloids. Hemoferrum is an invaluable constructive, or, more properly speaking, reconstructive, agent. It is useful in all forms of systemic depression marked by debility more or less general.

In convalescence from pneumonia, la grippe, typhoid fever, etc., it is very valuable in the treatment of chronic diarrhea and other wasting diseases.

In diseases of women, such as leucorrhea, weakness following childbirth, or from prolonged nursing, this tonic is especially useful.

A genuine tonic is then one of the most valuable medicines to be sought after in the present time, and in this preparation of hemoferrum we have a remedy worthy of both medical adviser and patient.

—New England Medical Monthly.

### WINE IN TABLETS.

A chemist of Algiers announces that he has invented a process for concentrating wine in tablets. Henceforth, we are told, travelers will be able to carry great casks of wine in diminutive boxes. The ripe grapes are taken, the stalks removed, and the fruit pressed. The liquid is then pumped into a vacuum evaporator, heat is applied, and at a sufficient temperature vapor is produced, which is passed into a refrigerator. The result is a thick and syrupy liquor, which is afterwards mixed with the grape pulp and pips. The mixture is pressed into tablets, which, it is alleged, will keep indefinitely. To make wine it is only necessary to add the amount of water which has been evaporated. A good wine, of fine flavor, and from eight to nine degrees of alcoholic strength is obtained. The tablets contain about 80 per cent. of grape sugar. It is suggested that the tablets, mixed with a little water or diluted in soup *maigre*, would prove very nourishing as a ration when campaigning or traveling.

## Here and There.

### A GRIM VIEW OF IT.

The death of an ossified man in Tennessee is reported. He died hard.—Chicago Tribune. This is as bad as the man who swallowed a thermometer and died by degrees; it suggests also the case of the consumptive undertaker who died of a coffin.—Medical Record. These remind us of a man who choked while eating an apple, and died of appleplexy.—National Medical Review. It was in a St. Louis hotel that a Pike county farmer blew out the gas and died from gastritis. Meyer Brothers' Druggist. Not any worse than the man struck by an engine; verdict, died from locomotor attackxia.—Montreal Pharm. Jour. Still worse the case of that pie-eating dyspeptic of Tiflis, for he died of piemia, superinduced by typholitis.—Gaillard's Med. Journal. The other day a negro in Southern Georgia ate six watermelons. He died of meloncholia.—Atlanta Med. and Surg. Jour. Not long ago we saw a trestle builder who had an aggravated case of piles. Nor any worse than the tailor who swallowed his tape measure and died by inches.

Cholera has caused 2,000,000 deaths in Russia since 1832.

A Judge in crossing the Irish channel one stormy night knocked against a well-known witty lawyer who was suffering terribly from seasickness.

"Can I do anything for you?" said the Judge.

"Yes," replied the seasick lawyer, "I wish your lordship would overrule this motion."

The estate of the late Dr. Henry G. Bigelow, one of the most widely known physicians of Massachusetts, is being sued for \$150,000 damages by a young lady who claims that the doctor promised to marry her, and that he would have fulfilled his contract had he lived. This constitutes a rather novel breach-of-promise suit.

A countryman was so impressed with a gas stove on exhibition in a city store that he invested in one, although there was no gas in the small village in which

he lived. He did not know why the thing would not work until he had made a second trip to the city with his complaint.

The driest place in the world is said to be in that part of Egypt between the two lower falls of the Nile. Rain has never been known to fall there.

A report shows that there are 2173 persons in the world known to have six fingers on one hand, and 431 with seven fingers.

There are nearly 2000 women practicing medicine in the United States.

A Georgia man who has been sick for a long time has prepared for his funeral even to the purchase of a coffin and the digging of a grave.

### BOOKS AND PAMPHLETS RECEIVED.

SONDERABDRUCK aus DERMATOLOGISCHE ZEITSCHRIFT. Herausgegeben von Prof. Dr. O. Lassar. Verlag von S. Karger in Berlin NW. 6.

FRACTURES AND THEIR TREATMENT. An address delivered before the Syracuse Academy of Medicine, February CAL SPLINT. By Gregory Doyle, M. D., cuse, N. Y. Reprint from the Buffalo Medical and Surgical Journal, March, 1894.

COLLES' FRACTURE THE ANATOMICAL SPLINT. By George Doyle, M. D., Syracuse, N. Y. Reprint from the International Journal of Surgery, July, 1894.

THIRTIETH REPORT OF THE TRUSTEES OF THE BOSTON CITY HOSPITAL, with Report of the Superintendent. For the year February 1, 1893, to January 31, 1894.

The report of the superintendent shows that 8292 patients were admitted during the year, of whom 3525 were medical, 3172 surgical, 890 contagious, 562 gynecological, and the remainder in special services. The number of accident cases received was 1495, the daily average in the wards 457, an increase of 24 over the previous year. The total number of deaths was 1153, of which number 447 died within forty-eight hours of admission, 203 of diphtheria. Solely for want of proper accommodations in the hospital, 428 persons had to be rejected.

The weekly cost per patient averaged \$10.00, while the average stay of patients in the hospital was 19.05 days.